Conclusions: Our findings suggest IFEDs are recruiting physicians largely from rural and underserved settings.

Implications for Policy or Practice: The recruitment of IFED physicians from rural and underserved settings taken in combination with evidence that freestanding emergency departments locate in areas with higher incomes and lower proportions of Medicaid patients; our findings raise concerns about the potential negative workforce and access side effects of these newer, entrepreneurial health care organization models.

Primary Funding Source: Health Resources and Services Administration.

Primary Care Physician Supply, Access to Care, and Market Adjustments to Physician Shortages

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Research Objective: To alleviate the problem of primary care physician (PCP) shortage, policy makers have established new medical schools and expanded medical school class sizes over the last 15 years. However, few studies have examined whether the increased PCP supply improves access to care. We aimed to fill the gap by examining the effect of PCP supply on adults' access to care and assessing the extent to which market adjustments mitigate PCP shortages.

Study Design: We used primary care service areas (PCSAs) as market areas and merged PCSA-level PCP supply (PCPs per 1000 population) with individual-level data from the 2004-2013 Medical Expenditures Panel Survey (MEPS). The data on physician supply and number of patients that PCPs saw per day came from SK&A while all other measures were from the MEPS.

We modeled the probability that adults had a nonemergency room usual source of care (USC) as a function of PCP supply and individual sociodemographic characteristics, health status, and beliefs and attitudes regarding health and health care. We estimated analogous models to examine how PCP supply affects travel time to the USC and the ability to get needed care right away and make appointments as soon as needed. To examine market adjustments, we assessed the relationship between PCP supply and whether PCPs offered night and weekend hours, how many patients PCPs saw per day, and how frequently individual adults had office visits. As sensitivity analyses, we tested alternative PCP definitions (eg, including vs. excluding obstetricians/gynecologists) and estimated the models separately for adults with and without health insurance. All the models controlled for nurse practitioners and physician assistants.

Population Studied: 378 400 adults included in the 2004-2013 MEPS.

Principal Findings: PCP supply had no effect on the probability of having a USC or the ability to get needed care right away or make timely appointments by adults. By contrast, higher PCP supply reduced adults' travel time to the USC. We also found evidence of market adjustments that enhanced the physicians' capacity to see different patients in areas with low PCP supply. Specifically, PCPs in these areas were more likely to offer night and weekend hours and saw more patients per day (elasticity at mean = −0.19), while adults in these areas had fewer office visits (elasticity at mean = .07). Taken together, the latter two adjustments compensate for more than one-fourth of the lost capacity to see different patients where there are fewer PCPs. The sensitivity analyses confirmed robustness of the results.

Conclusions: Since both having a USC and the ability to get timely care when needed and make timely appointments are likely to be more important indicators of access than travel time to the USC, our findings suggest that more PCPs do not improve the most important access indicators for most U.S. adults. Market adjustments in areas with fewer PCPs are at least partly responsible for the lack of effects of PCP supply on having a USC.

Implications for Policy or Practice: Producing more physicians may be a blunt instrument for improving access to care. Targeted policies are likely to be more efficient in improving access for adults who currently lack it.

Primary Funding Source: Agency for Healthcare Research and Quality.

The Impact of Gender, Race/Ethnicity, and Children on Wage Disparities Among Active Clinical Physical Therapists

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Research Objective: Pay inequality continues to be more persistent in particular occupations, such as the medical/health care setting. According to a study in Social Science and Medicine, even within traditionally female-dominated occupations such as Nursing and Physical Therapy (PT), men continue to earn more than their female colleagues. One study by Williams found that wages within female-dominated professions/occupations were lower overall in comparison with the male-dominated professions/occupations. Currently, there are approximately 230 000 PTs in the United States, with females comprising approximately two-thirds of all active clinical physical therapists. The average PT salary is $67 106.00, with men averaging $80 761 and women averaging $61 360. Previous research has found both racial/ethnic wage disparities, as well as gender disparities. Recent research suggests that gender gaps in salary may be due to time taken off work for child care. The purpose of this study is to go beyond previous research by explicitly taking into account the confluence of gender, race/ethnicity, and the household presence of minor children in the analysis of wages within Physical Therapy.

Study Design: Secondary data analysis using the 2012-2016 American Community Survey Public Microdata Sample (ACS PUMS)

from the U.S. Bureau of the Census was employed. Statistical techniques included bivariate and multivariate regression analyses.

Population Studied: The 2012-2016 American Community Survey Public Microdata Sample (ACS PUMS) contains over 15 million respondents and is representative at the state and national levels; 12 311 nonmanagerial physical therapists in active clinical practice were selected for this analysis. Salary was computed by first calculating hourly wage, based on county of employment, then multiplying by 2080 (40 hours/week for 52 weeks/year) to standardize to a full-time annual salary. Salary was further standardized by adjusting for the county-level cost of living index (COLI), computed by the Council for Community and Economic Research. Only PTs working 32 hours per week or more aged 50 and under were analyzed. Combinations of gender, race/ethnicity, and presence of children under 18 in the household were calculated and run as a series of dummy variables. Blacks and Hispanics were combined to increase sample size. Age, educational attainment, and marital status were included as control variables.

Principal Findings: Compared to White non-Hispanic males, Black and Hispanic women earn the least, followed by White non-Hispanic females, followed by Black and Hispanic males, and followed by Asian non-Hispanic females. Only Asian non-Hispanic males earned more than White non-Hispanic males. The presence of minor children at home did not explain wage gaps between males and females.

Group	Annual Difference in Full-time PT Salary Compared to White Non-Hispanic Males
Black/Hispanic females w/minor children	−$14 185
Black/Hispanic females no minor children	−$13 348
White non-Hispanic females w/ minor children	−$10 073
White non-Hispanic females no minor children	−$10 137
Black/Hispanic males	−$8794
Asian non-Hispanic females no minor children	−$8150
Asian non-Hispanic females w/minor children	−$3907
Asian non-Hispanic males	+$226

Conclusions: Serious wage disparities exist by race and gender that cannot be explained by the presence of children, education, or years working.

Implications for Policy or Practice: Further research into organizational practices and policies is warranted to determine the role of potential bias and discrimination.

Wage Discrimination within Health care Professions: An Intersectional Analysis

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Research Objective: The goal of this project was to analyze the degree to which gender discrimination and black-white racial wage discrimination exist within the US health care workforce. Additionally, this project utilizes a critical race theoretical framework to explore how individuals with intersectional identities, specifically black women, are impacted by these wage differences.

Study Design: Our project uses the 2010-2018 pooled samples of the American Community Survey, a household survey conducted by the US Census Bureau and extracted using the Integrated Public Use Microdata (IPUMS) data tool. This study uses Blinder-Oaxaca wage decomposition to analyze gender and race wage differentials. To analyze wage differentials, we used the Blinder-Oaxaca decomposition method. To capture intersectionality, we conduct a series of specific decompositions to capture the reality of black women within the health care workforce. First, we ran a decomposition analysis to identify and quantify the degree to which individual endowments contribute to gender wage differentials at each earning level. Next, we ran a similar analysis to identify the cause of racial wage differentials. Next, we ran two analyses that compared (1) white men and black women and (2) black men with white women. Each decomposition took into account wage differences at each earning level. A series of robustness checks were also conducted to check the validity of our decomposition results.

Population Studied: This sample of over 1.5 million individuals includes all individuals who reported being employed within the health care industry. This sample excludes managers and those in administrative position but does include individuals from a broad range of earning levels and includes technicians as well as specialists and surgeons.

Principal Findings: Gender and racial wage differences do exist within the health care workforce. Our results show that only 67% of the differences in wages between white men and black women can be attributed to skill-based differences. This finding suggests that 33% of this difference is unexplained and may be attributable to wage discrimination. However, we find that compared to white women, black men may be experiencing some forms of positive discrimination as skill-based differences fail to account for the observed wage differentials. Overall, we see that black women have the lowest wages at all earning levels within our sample.

Conclusions: The analytic findings of this study confirm existing racial and gender wage disparities within the health care workforce. Our intersectional analyses suggest that black women are uniquely disadvantaged within the health care workforce. In order to achieve critical racism theoretical practice, it is important for the health care industry to not replicate the system disadvantage that people of color, and specifically black women experience in other aspects of our society.